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7 August 2024

SUBMISSION - REVIEW OF HDC

EXECUTIVE SUMMARY

CONTEXT

[redacted]. Our services are grounded in our commitment to resident-led, evidence-based, and culturally appropriate practice, and served by a comprehensive approach to quality including an emphasis on seeking and responding to all feedback. Our practice is constantly reviewed and refined, and we continue to learn, grow, and innovate as a provider. Our commitment to quality incorporates a genuine engagement with external quality assurance processes and sector oversight. Our experience with the HDC complaints process is through the Aged Care Commissioner's Office and provides us with insights into the process as it is experienced by providers as respondents. From this perspective there are several opportunities to simplify and consolidate the complaints process. We believe these changes would result in a more efficient and engaged process, grounded in an unbiased, respectful, and timely approach to interacting with complainants and respondents.

RECOMMENDATIONS

-that a more engaged approach to managing HDC complaints incorporating the opportunity for interaction between the complainant and provider/respondent be developed. (The mediation process provided by the Human Rights Commission is an example of an approach that provides the opportunity to consider and respond to issues of concern and seek resolution.)

-that the HDC adopt a neutral approach to communication with all parties involved in a complaint to avoid any sense of bias or predetermination of outcome.

-that a process of preliminary investigation evaluating key questions (such as whether the level of care outlined in the complaint aligns with the assessed need of the resident and that which is provided on the site) be adopted. This could clarify and potentially simplify the complaint, investigation, and outcome processes.

-that a more generic approach to communicating complaints to respondents be adopted that centres on identifying key points in complaints which providers/respondents are then invited to respond to.

-that a clear process, touchpoints, and timelines for processing complaints be outlined and strategies put in place to enable it to be followed for the benefit of all parties.

-that the HDC review how it requests information with a view to ensuring those involved are treated confidentially, respectfully and not identifiable unless absolutely necessary and if so with appropriate support.

-that the HDC establish an advisory or reference group of aged care providers to ensure balanced engagement with the sector.

SUBMISSION

[redacted]

The provision of aged residential services is complex. The needs and preferences of individual residents often exist in the context of what their family or advocates believe and value, and the provision of genuinely engaged care and support, requires navigating a wide range of regulatory and resourcing challenges.

We are committed to providing high quality care and support and to ensure that we maintain confidentiality, dignity, choice, safety, and best practice as we do so. Our model of clinical governance reflects our commitment to engaging with residents, teams, and expertise and we are actively engaged with sector-wide benchmarking of clinical indicators within a comprehensive approach to practice and policy development. We contribute to the wider sector by engaging with research and learning initiatives and place a high value on feedback, transparency and accountability.

We acknowledge that from time to time in the process of providing health care and disability support there are situations that do not unfold as we would expect. We are open to all feedback and actively engage with processes of review, from a perspective of seeking to understand, learn and implement change. We appreciate the need for external monitoring and review, and mechanisms that assure the public that services are fit for purpose and safe. While it is disappointing that experiences and situations require investigation and external scrutiny, we engage with these matters with integrity and a genuine desire to address issues and to respect the people and perspectives involved. We support the existence of processes and systems that represent the views and experiences of residents within our service. We engage with feedback and complaints, including those involving external agencies, and always seek to reach an appropriate resolution, acknowledging that this will involve communication, reflection and learning, along with explanations, apologies, and at times, censure.

We welcome the opportunity to provide a submission regarding the review of the HDC (Code and Act). Our experience as a provider navigating the HDC (Office of the Aged Care Commissioner) processes specifically relates to the complaints process. Themes within our experience and feedback are outlined below and extend to broader review topics such as equity, appeal processes, and the administration of the complaints process itself. In providing this submission we have taken care to position our contribution within a positive frame and we do this in the spirit of contributing to change, and refinement of practice. We have engaged with the HDC in an attempt to raise concerns about various matters in the past and trust that participating in this process will mean our experience can inform ongoing refinement of practice and processes.

The needs of complainants

We acknowledge that when a complaint is received by the HDC the complainants have acted with intention to raise matters of concern. As with all complaints our approach is to genuinely engage with the issues raised and appreciate the perspective of the complainant. It is common for complainants to misunderstand the situation that has occurred. Sometimes there is a misunderstanding of an event, a piece of information, or the context in which they experienced these things. It is understandable that, in the absence of specific information, concerns may escalate and compound. The HDC processes as we experience them are overwhelmingly complex and lengthy for both

complainants and providers/respondents and there are missed opportunities to address simple matters and resolve concerns.

The need to be heard and to have a sense of closure is a common issue for complainants and we place great value on seeking relevant and meaningful ways of engaging with residents and whānau as we explore and respond to complaints. The timeliness of offering to engage and meet has the benefit of enabling the parties to move through the process as smoothly as possible. We have good examples of situations in which the engagement over a tightly held complaint has led to very positive interactions including policy and practice changes, grounded in acknowledging the complaint that initiated the process.

From time to time there are interpersonal and family dynamics that intersect at the point of complaints. While these situations are always unfortunate it is not unusual for there to be an element of tension between complainants and those around them as they do not agree about the details or manner of the complaint. There are situations in which complainants have been involved in other processes, including coronial investigations, but feel they have not been heard and they express that they are seeking apology. It is not reasonable to expect that staff who were on a particular shift several years earlier are still employed, remember the events, perceive the situation the same way as the complainant, and should be required to formally apologise. However, our approach is to respond and answer as many questions as possible.

In some situations, an HDC complaint has traversed a number of agencies and processes prior to being presented to a provider by the HDC. This can include one issue or situation being repeatedly presented to Te Whatu Ora for investigation and response, more than one advocacy service, complaints to Te Whatu Ora and other government and funding agencies, police and coroner. Such complaints pathways have involved the provider in responding on a number of occasions and providing considerable information and analysis. The resources involved in these situations are considerable and repeated investigation and detailed response does little to address the core issues of grief, unresolved trauma, family dynamics, or other distress. As these situations evolve over several years the likelihood that the staff involved are still employed and able to accurately recall the situation reduces significantly. It is often no longer possible to locate the staff who were involved, it is unreasonable to be expected to enter into analyses of precise statements that were made during the specific interaction in question, and it is confronting and intimidating for staff to be asked to re-engage. We appreciate these are very challenging situations for those involved and that a sense of closure is sought. However, it is not clear that managing these ongoing and escalating situations is an appropriate use of resources for the HDC or the provider, and a more suitable process for the complainants should be explored.

The HDC complaints process as it stands is lengthy and this extends the period of time between the experience or situation of concern and the outcome. *We suggest that a more engaged approach to managing HDC complaints incorporating the opportunity for interaction between the complainant and provider/respondent be developed. (The mediation process provided by the Human Rights Commission is an example of an approach that provides the opportunity to consider and respond to issues of concern and seek resolution.)*

The framing of complaints

We appreciate that the nature of making a complaint involves raising issues of concern and that these are likely to be negative. The HDC references its approach as 'fair, timely, and effective' however, the framing of complaints by the HDC to providers tends to assume the perceived incident or event occurred as documented by the complainant. This approach positions the provider/respondent as having caused the situation or acted in bad faith which it now needs to defend. Some complaint

letters from the HDC include information directly from the complainant's communication and when this is formatted into the HDC letter to providers as respondents suggests an adversarial position, supported by the HDC. *We suggest that the HDC adopt a neutral approach to communication with all parties involved in a complaint to avoid any sense of bias or predetermination of outcome.*

Triage and preliminary investigation

Triage processes have the potential to enable issues to be dealt with quickly, affording a positive outcome for everyone involved. We have experienced situations in which allegations are based on misunderstandings such as a belief that a resident had been given a particular medication as indicated by an attending health professional. A simple analysis of blood results and review of the clinical records from the attending clinical service could address such a situation and help the complainants to understand how this misunderstanding occurred. This would be preferrable to the prevailing experience of extensive documentation being sought and exchanged over lengthy periods of time.

A process of preliminary investigation has the potential to clarify the key points within complaints. An example of an opportunity for this to make a positive difference would be when a complaint requires detailed information about the provision of a specific level of care that is neither provided on the site concerned or aligned with the level of assessed need of the resident concerned. It is unreasonable to be asked to provide information about the secure management of areas within a building that is not certificated to, nor purports to provide, secure care and support. *Our suggestion is that a process of preliminary investigation evaluating key questions (such as whether the level of care outlined in the complaint aligns with the assessed need of the resident and that which is provided on the site) be adopted. This could clarify and potentially simplify the complaint, investigation, and outcome processes.*

Extent of required response

It is common for complaints to providers from the HDC to require the provision of extensive amounts of detail, including very personal health information. This can extend to several hundred pages of carefully mapped, summarised, and linked documents. At times the level of detail required is so extensive that clinical platforms are unable to provide it all. A request to provide a history of charted activities that amounts to several thousand entries is a good example of this.

Another example of extensive information is the request for video footage. Such requests have the potential to create confidentiality issues for staff, for other residents, and to disclose personal and potentially intimate information. It is reasonable for a summary of video footage relating to a specific period of time to be requested. In situations in which we have been concerned about the release of video footage we have provided an explanation of our concerns about this, along with written analysis of the video images. Despite our genuine concerns about providing video footage responses from the HDC have implied that we are deliberately withholding information and challenging the power of the HDC in doing so.

It has become increasingly common for the HDC to require that all staff involved or impacted by the situation or event in question to be informed of the complaint and have an opportunity to respond to it. It is good practice to engage relevant members of the team to share information from the complaint, and ensure opportunities for them to respond and reflect. However, the practicality of this approach as an HDC requirement of providers is questionable, primarily because of the relatively high turnover of staff in the sector, and the time it takes for complaints to be processed. Identifying individual staff from a specific shift a number of years earlier may be possible, but it does not follow that their recollection of events is accurate, and it is common for them to feel intimidated when offered the opportunity to respond to such complaints.

Very prescriptive requests for information are not always relevant, and requests for InterRAI assessments, and 'root cause analysis' of incidents are examples of these. There is good evidence that 'root cause analyses' are not always appropriate when investigating health care incidents as there is rarely a single route cause. Often requests are made for specific policies. However, the titles of requested policies do not always align with the way providers design and name their policies. This very prescriptive approach implies that there is a right and wrong way to document policy and potentially limits opportunities to provide the most relevant policy and practice guidance.

The insistence on respondents providing extensive amounts of information has the impact that the investigation process takes longer than it may need to. *Our suggestion is that a more generic approach to communicating complaints to respondents be adopted that centres on identifying key points in complaints which providers/respondents are then invited to respond to.*

Progression of complaints

The time it takes for complaints to be resolved is particularly long, extending to a number of years. This makes it particularly difficult to follow up issues as memory, policy and practice evolves, staff move on, and perspectives change. It is common for even the most extensive responses to complaints to be deemed insufficient by the HDC, with additional information being requested, one or more years after the initial response was complied, and usually without acknowledgement that the original request for information was fully met as requested.

There is a tendency for new and additional allegations to emerge during the period of the HDC investigation. A misreading/misinterpretation of a single note in a progress record, years into an investigation process, can lead to the assertion that a specific incident (significant enough to be a breach of the code) occurred, and the provider had failed to document it and follow up.

The process of sending complainants and providers provisional outcomes has the potential to relitigate and further delay outcomes. In some situations, complainants extend the complaint resulting in a further escalation as the HDC then requires additional issues to be addressed. It is likely to be more articulate and informed complainants who engage in these processes, which is arguably an equity issue in itself. In other situations, the attempts by providers to clarify how they have been represented in a proposed outcome is interpreted by the HDC as a challenge to due process. It is common for the HDC to note the timeline they have given providers to respond has been extended by a period of weeks. This 'additional' time does not correspond with the years it takes for complaints to be resolved by the HDC and seems rather inequitable.

Delays with the processing and finalising of complaint outcomes has far reaching impacts as external audit/certification periods are expressly impacted by there being any 'open' HDC complaints. While the certification outcome is the remit of HealthCERT it is their interpretation of the status of HDC complaints that has a direct and detrimental impact on the outcome and potentially reputation of the provider. *Our suggestion is that a clear process, touchpoints, and timelines for processing complaints be outlined and strategies put in place to enable it to be followed for the benefit of all parties.*

Engaging with HDC

The process of managing the complaints process and communicating with complainants requires neutrality and balance. The establishment of the role of the Aged Care Commissioner as an advocate and the promotion by the HDC of the complaints process as a primary point of contact potentially creates some challenges for respondents.

The position of the Aged Care Commissioner as an 'advocate for quality health and disability services on behalf of older people' that 'provides oversight of the aged-care sector' can lead to the role being interpreted as an ally of complainants and, given the default adversarial approach of the HDC, therefore in opposition to providers. The language and tone of communication from the HDC to providers tends to assume the complaint is the single source of truth and the provider must defend itself against the allegations within it.

All providers of health and disability services are required to meet quality standards for the design and delivery of services and are subject to external review and scrutiny. These requirements include having a complaints process and system for responding to issues that may be raised by service users or their advocates. Positioning the HDC as a point of contact for complaints creates additional complexity as some complaints are sent to providers and the HDC at the same time. In line with the provider's policy complaints are investigated and responded to within a defined time frame (usually within 10-14 days). At the time of investigating and responding the provider does not know if the HDC will require a response to the complaint. When this does occur the initial response from the provider can only be included as one part of the HDC response as they require extensive details and information and investigate the complaint de novo.

It is common for the HDC to request information about people including personal contact details of staff. The requirement to provide video footage has the potential to disclose personal information not directly related to the complaint at hand. The release of such comprehensive clinical information also potentially identifies people (other residents, staff, family, visitors). The process of redacting these details from clinical records is enormous and there are risks that some information will be missed. As the HDC is subject to the Official Information Act the information provided in response to complaints can be released and this means that personal health information of individuals and other information of those referred to within the documentation may be disclosed. The HDC notifies providers when an OIA request has been made but does not allow reasonable engagement to ensure that people are not identifiable prior to releasing all information provided by the respondents. Employers have a duty of care to their staff and are reasonably concerned when the HDC requires the provision of personal contact details. We have experience of our genuine concerns about staff being disregarded by the HDC. Staff feel intimidated when the HDC intends to contact them directly about an event that occurred years ago. *Our suggestion is that the HDC review how it requests information with a view to ensuring those involved are treated confidentially, respectfully and not identifiable unless absolutely necessary and if so with appropriate support.*

There are many administrative processes involved in managing complaints and responses to them. The details of these processes vary from time to time and apparently at the preference of individual HDC staff. Difficulties with passwords, sending documents to the wrong people, or to email addresses that are clearly no longer in use and with redirections in place, are complications that cause further delays for complainants and providers. These administrative issues should be simply managed but are rarely resolved quickly or easily.

The need to ensure complainants are treated with respect and sensitivity is clear. From time-to-time complainants express their upset very strongly and the HDC website makes reference to the expectation that staff are treated with respect. Unfortunately, providers and respondents do not always experience balance and respectful interactions when engaging with the HDC. There is an opportunity to ensure that in the interests of natural justice providers are not positioned as being at fault. Addressing this issue requires renewed attention to the tone and language of communication with providers as they are asked to respond to complaints. The formal processes of inquiry and investigation do not need to be legalistic and should be neutral and balanced for all parties. The emphasis on the role of the Aged Care Commissioner as an advocate potentially establishes a context

which positions providers as adversaries. *Our suggestion is that the HDC establish an advisory or reference group of aged care providers to ensure balanced engagement with the sector.*

Conclusion

The need for an agency to oversee and respond to complaints about care and experience of people receiving services from the health and disability sector, is clear and understood by aged care providers. The experience providers have of the complaints process provides them with insights into the system as it currently operates and informs recommendations for change.

The complexity of the current system results in delays in resolution of complainants and requires extensive resources for providers, along with the detrimental impact that having an 'open' HDC complaint has on audit outcomes. Responding to HDC complaints through the current processes is time consuming and resource intensive. The resource contribution that involves duplicating investigation and extensive documentary evidence would be better directed to the provision of aged care services and their related quality systems. There is an opportunity to refine the processes the HDC uses to frame and process complaints and a need to ensure balance and fairness for providers as they respond to complaints. Overall, a cultural approach that is more inquisitorial, respectful, and collegial than adversarial, cumbersome, and legalistic would serve all parties better.

The very nature of a complaint means there is a matter that needs attention and resolution. The HDC has an opportunity to refine its processes and approach to ensure balance and fairness for all in the process.

Our intention in presenting this submission is to contribute positively to the review process. Our experience of the HDC processes as a provider are less than satisfactory in many aspects. However, we are committed to contributing to innovation and practice development and appreciate the need for oversight, investigation, and constant evolution. It is our hope that a culture of engaged, progressive and respectful engagement with complainants would also extend to providers and others who respond to the complaints presented by the HDC, and specifically the Office of the Aged Care Commissioner. It is in the interests of all agencies, providers, teams, and individuals serving the aged care sector to engage positively with one another and to work for the constant development and refinement of service provision. We are open to meeting and discussing specific issues and points outlined in this submission in more detail and note that any information within this submission that identifies our organisation, staff, residents, complainants, or specific complaints must not be disclosed, including in response to any OIA requests.